OVERVIEW

The Emergency Services Program encompasses AHCCCS coverage of services for most immigrants, including undocumented/illegal immigrants.

The Federal Emergency Services (FES) program is federally funded and provides emergency services only to immigrants, including undocumented immigrants, who are eligible for Medicaid except for their immigrant status. Medicaid eligible means a person who is aged, blind, disabled, a pregnant woman, a child, or parents of a dependent child who meets the federal income requirements.

Funding for the State Emergency Services (SES) program was eliminated from the fiscal year 2004 state budget, effective July 1, 2003. The SES program was funded exclusively with state funds. It covered individuals who were either undocumented or non-qualified aliens who would not otherwise have qualified for FES. Typically these were single adults.

Recipients seen under the SES program on or after July 1, 2003 may be billed directly for any medical services provided, as they are no longer covered by AHCCCS.

The Department of Economic Security is responsible for the majority of eligibility determinations for both programs.

By federal mandate, the following *lawfully admitted* immigrants are eligible for full medical services, regardless of date of entry.

- ☑ Veterans honorably discharged, spouses, and minor children
- ☑ Immigrants on active military duty, spouses, and minor children
- ☑ Asylees and refugees
- ☑ Individuals granted withholding of deportation

COVERED SERVICES AND LIMITATIONS

FES recipients are eligible for emergency medical services and delivery services only.

Effective November 1, 2001, the services billed must meet the federal definition of emergency services as defined in federal law in 1903 (v) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement.

COVERED SERVICES AND LIMITATIONS (CONT.)

☑ Emergency services are services that:

- ✓ Are *medically necessary*, and
- ✓ Result from the *sudden onset* of a health condition with *acute* symptoms, and
- ✓ Which, in the absence of *immediate* medical attention, are reasonably likely to result in at least one of the following:
  - ☒ Placing the individual's health in *serious jeopardy*, or
  - ☒ *Serious impairment* to bodily functions, or
  - ☒ *Serious dysfunction* of any bodily organ or part.

Only services that fully meet the federal definition of an emergency medical condition will be covered. Not all services that are medically necessary meet this definition.

Newborns born in the United States may be eligible for comprehensive medical services.

NOTIFICATION REQUIREMENTS

Inpatient facilities providing emergency services in excess of three days or ICU/CCU care in excess of 24 hours must notify AHCCCS so that AHCCCS can initiate concurrent review.

Effective November 1, 2001, extended services packages will not be authorized. In accordance with the Balanced Budget Act, prior authorization cannot be required for emergency services. Each time emergency services are delivered to an FES recipient, the federal criteria for an emergency medical condition must be met for the claim to be considered for payment.

BILLING AND DOCUMENTATION REQUIREMENTS

FES recipients are not enrolled in health plans, and they have no primary care physician. Claims for services are reimbursed by the AHCCCS Administration on a fee-for-service basis.

CMS 1500 billers must check the emergency box (Field 24I) and UB-92 billers must enter a "1" in the Admit Type (Field 19) to identify the services billed as an emergency.

All claims for services provided to recipients eligible under the FES program will be reviewed by the AHCCCS Administration on a case-by-case basis. Facility and physician claims must be submitted to AHCCCS with documentation that supports the emergent nature of the services provided.

Examples of documentation include operative report, progress note or summary letter, etc. The documentation must verify the medical emergency as defined in the federal guidelines. Providers should not attach the entire medical record.

Claims submitted without documentation will be denied because AHCCCS will not be able to verify the emergent nature of the services billed on the claim.

Providers should follow all other applicable billing instructions in this manual.

SPECIAL INSTRUCTIONS FOR MATERNITY CLAIMS

Effective November 1, 2001, maternity claims for FES recipients must be billed using the appropriate CPT code for delivery services only. Claims for FES recipients billed with a global CPT code will be denied because routine prenatal services are not covered under the FES program.

Providers may only bill the following codes for labor and delivery services for FES recipients:

- ☑ 59409 - Vaginal delivery only
- ☑ 59514 – Cesarean delivery only
- ☑ 59612 - Vaginal delivery only, after previous Cesarean delivery
- ☑ 59620 - Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery

ADDITIONAL INFORMATION

☑ Questions about *covered services* should be directed to the AHCCCS Office of Special Programs at (602) 417-4053.

- ✓ Information also is available in the *AHCCCS Medical Policy Manual (AMPM)* on the AHCCCS web site at www.ahcccs.state.az.us.

☑ Questions about *billing* should be directed to the AHCCCS Claims Customer Service Unit at:

(602) 417-7670 (Phoenix area)

(800) 794-6862 (In state)

(800) 523-0231 (Out of state)